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H.R. 3162—Children's Health and Medicare Protection Act of 2007

PRELIMINARY ASSESSMENT

July 31, 2007

Summary: H.R. 3162 reauthorizes and significantly expands the State Children's Health Insurance Program (SCHIP), provides Medicare payments for physicians, hinders Medicare Advantage plans, and includes several extensive provisions (including tax increases) to *partially* offset the bill's costs. Highlights of the bill are as follows:

Cost:

- **PAYGO Violation.** H.R. 3162 provides $27.5 billion over five years and $132.6 billion over ten years in new mandatory spending. This new spending is only partially offset by tax increases, $28.9 billion over five years and $59.7 billion over ten years. As a result, the bill reduces the deficit (in part with a budget gimmick pertaining to physician reimbursements, see below) over five years, but *increases* the deficit over ten years—*by $72.9 billion over years.* Therefore, H.R. 3162 is subject to a PAYGO point of order under the Rules of the House, unless further modified.

SCHIP:

- **Permanent Entitlement**. Under current law, a federal block grant is awarded to states to provide health insurance to children from families with income *above* Medicaid eligibility levels. From the total annual appropriation, every state is allotted a block of funding for the year (its "original allotment"), based on a statutory formula. H.R. 3162 would provide that state's annual allotment would be the greater of a state's projections of enrollment for FY 2008 or the state state's FY 2007 allotment, increased by the growth in the number of children and national healthcare expenditures. Unlike in the past, where a state would receive a set amount of funding each year, H.R. 3162 provides an escalating allotment that increases as the state expands coverage and increases enrollment—even to individuals (pregnant mothers and childless adults) outside the scope of the program's original intent—*children*. In addition, the bill contains no sunset date, as the original SCHIP legislation provided, meaning these mandatory increases will be on auto-pilot in the future.

- **Encourages Spending**. H.R. 3162 shortens from three to two years, the amount of time a state has to spend its annual SCHIP allotment. Under current law, states are given three years

to spend each year's original allotment, and at the end of the three-year period, any unused funds are redistributed to states that have exhausted their allotment. In addition, the bill establishes a process through which any unspent state funds would be evenly redistributed to any states with a shortfall in funding. This new statutory formula is essentially the same distribution process that results when Congress has appropriated additional SCHIP funding for shortfall states, thus further providing an incentive for states to spend their allotment and more by offering additional services and benefits.

- **Broadens Eligibility**. H.R. 3162 places *no limit* on SCHIP eligibility. Instead, the bill would allow states to establish their own eligibility standards—so to whatever extent a state enrolls children in the program regardless, the government would continue to fund coverage for those individuals. In many cases, this would allow children from families at 400% of poverty to be covered by SCHIP, but states could expand coverage for increasingly well-off beneficiaries if they chose—and would have an incentive to do so, since their funding allotment would increase.

  It is important to note that SCHIP was designed to target uninsured children from families with an income at or below 200% of poverty. Under current law, states with Medicaid eligibility levels nearing the 200% mark, can extend SCHIP coverage to those at 50% above Medicaid eligibility. According to the Heritage Foundation, 15 states have expanded coverage to children exceeding 200% of poverty, nine of which have set eligibility at 300% or above. The current poverty level for a family of four is $20,650.[1] Increasing eligibility to 400% of poverty would result in providing SCHIP coverage to children from families *with annual income of $82,600*. Under this scenario, it would be possible for a family to qualify for SCHIP coverage and also be subject to the Alternative Minimum Tax (AMT), a tax imposed on higher-income individuals to ensure they pay a minimum level of federal taxes.

  In addition, the bill loosens the definition of "children" covered under SCHIP and Medicaid from 19 to 25. Nor does the bill prohibit the numerous federal waivers given to states to cover individuals who are not children. SCHIP spending has significantly increased as states have chosen to cover other populations. Similarly, under current law, most states have chosen to cover pregnant mothers through the waiver process. However, H.R. 3162 creates a new straight forward eligibility option for SCHIP to cover pregnant women (removing the need for a waiver) and provides that the child born to the pregnant mother would be automatically enrolled in the program.

- **Discourages Asset Tests**. H.R. 3162 would provide "bonus payments" or additional funding to states that do not subject individuals to assets testing in determining SCHIP eligibility. Under the proposed scenario, a family could hold assets in excess of $1 million (a house, a car, etc), yet still qualify for SCHIP if their income level met their state's income requirements.

- **Legal Immigrants and Citizenship Certification.** The bill allows states to provide SCHIP and Medicaid coverage to legal immigrant children and pregnant women. The bill also retroactively repeals citizenship documentation requirements that were implemented in the

[1] Department of Health and Human Services: http://aspe.hhs.gov/poverty/07poverty.shtml

Deficit Reduction Act of 2005 and fails to require enrollees to provide documentation of citizenship.

- **New Children's Commission.** The bill establishes a Children's Access, Payment, and Equality Commission, that would be responsible for reviewing: 1) the federal and state Medicaid and SCHIP payment policies, 2) access to, and affordability of coverage and services for Medicaid and SCHIP enrollees, 3)the impact of Medicaid and SCHIP payment policies on access to services, and 4) the impact of Medicaid and SCHIP policies on reducing health disparities, including geographic disparities and disparities among minority populations.

Medicare Beneficiary Changes:

- **Preventative Services**. The bill adds several new benefits to preventative items and services covered under Medicare, including prostate cancer screenings, medial nutrition therapy services, screening mammography, and bone mass measurements.

- **Mental Health Coinsurance**. H.R. 3162 gradually reduces coinsurance for mental health services from 50 percent to 20 percent by 2012.

- **Medicare Assets Tests**. H.R. 3162 increases to $17,000 (up from $10,000) the amount of allowable resources for an individual to qualify for Medicare Parts B and D assistance. Increases this amount for families to $34,000 (up from $20,000), and increases these limits by $1,000 and $2,000 respectively, annually beginning in 2010.

- **Cost-sharing Limit**. The legislation limits total out-of –pocket spending for certain seniors covered by Medicare D (prescription drug coverage) to 2.5 percent of their annual income

Medicare Physician Payments:

- **Increased Physician Payments**. H.R. 3162 provides $21.1 billion over five years, and $102.7 billion over ten years to increase Medicare payments to physicians. However, the bill includes language to artificially limit the provision's scoring impact by scheduling a 12% cut to physicians in both 2010 and 2011. In short, the bill spends $102.7 billion over ten years, while subjecting physician reimbursement to significant cuts in the out-years. Under current law, doctors providing health care services to Part B enrollees are compensated through a "fee-for-service" system, in which physician payments are distributed on a per-service basis, as determined by a fee schedule and an annual conversion factor (a formula dollar amount). Every November, CMS announces the statutory annual update to the conversion factor for the subsequent year.

  From 2002 to 2006, the statutory update resulted in a negative update, which would have reduced physician payments. The negative updates occurred because Medicare spending on physician payments increased the previous year beyond what is allowed by one of the factors considered in the formula—the sustainable growth rate (SGR), which is a target for aggregate growth in Medicare physician payments. The SGR mechanism was designed to balance the

previous year's increase in physician spending, with a decrease in the next year, in order to meet the aggregate growth targets. As a result of increased Medicare spending in recent years, the statutory formula has resulted in negative annual updates. However, since 2003, Congress has chosen to override current law, providing doctors with increases each year, and level funding in 2006. This legislation would provide a .5% update (increase) in physician payments for 2008 and 2009.

H.R. 3162 eliminates the use of the sustainable growth rate mechanism used to contain the growth of Medicare physician payments. H.R. 3162 would replace the current SGR mechanism that affects all services equally, with a new system of six classes of physician services within the Medicare fee schedule that would each be updated with a mechanism similar to SGR, based on the growth in gross domestic product (GDP), except the Primary and Preventative Services category, which would be updated at GDP plus 3%. Different types of services are growing a various rates—for example, imaging services would continue to grow significantly each year, while surgical services would grow at a much slower rate. The new system is designed to provide updates for these six different categories based on their own growth target and GDP. Some conservatives may be concerned that the bill eliminates SGR, a form of cost-containment for Medicare's growing cost, which while perhaps flawed, at least required an annual discussion of the costs involved with increasing physician payments that normally led to an accompanying offset.

Medicare Advantage:

- **Medicare Advantage Payments**. H.R. 3162 reduces payments to Medicare Advantage (MA) plans over four years until the reimbursement rate equals 100% of fee-for-service Medicare. According to CBO, this provision saves $50.4 billion over five years and $157.1 billion over ten years.

  Almost 20% of seniors (over 8 million) in the Medicare program receive their Medicare benefits through private health plans under the Medicare Advantage program. Since MA plans provide on average $1,000 more in benefits to participants than traditional Medicare, reducing MA payments will likely discourage many private plans from participating in the program, perhaps eliminating the private Medicare option in many areas and for many individuals.

  As such, seniors could either lose their current health care provider and insurance or be subject to increased costs and decreased services. According to the Administration, fifty-seven percent of seniors enrolled in MA are in the lowest income range—from $10,000 to $30,000, and many of the services provided through MA to these beneficiaries are not provided to seniors through the traditional fee-for service Medicare. In addition, the reductions to MA will likely severely impact seniors living in *rural* areas. For instance, Congress aligned payment levels to encourage private plans to provide coverage in rural communities where costs are typically higher. By eliminating this incentive, H.R. 3162 would significantly decrease access to private coverage in the rural areas, forcing seniors back into traditional Medicare.

- **Medicare Advantage**. The legislation renames Medicare Advantage as Medicare Part C.

- **Cost Limitations**. H.R. 3162 limits the out-of-pocket cost for seniors participating in the MA program for any service to no more than the amount of cost-sharing for the same service in traditional fee-for-service Medicare. Again, since MA Plans offer more generous benefits than traditional Medicare, their costs are greater. By reducing the amount of cost-sharing they can require, while reducing reimbursements, this provision further threatens the viability of the MA program.

Medicare Parts A and B:

- **Payment Reductions**. Reduces or freezes Medicare payments to a number of health care providers and services, including the following:
    - Inpatient hospital payments (saving $1.1 billion over five years, $2.7 billion over ten years);
    - Inpatient rehabilitation facility services (saving $2.4 billion over five years,$6.6 billion over ten years);
    - Home health payment update (saving $2.6 billion over five years, $7.2 billion over ten years);
    - Long-term care hospitals (saving $500 million over five years, $1.3 billion over ten years); and
    - Skilled nursing facility payments (saving $2.7 billion over five years, $6.5 billion over ten years).

- **Medical Equipment Provisions**. The bill prohibits immediate purchase of power-driven wheelchairs, and reduces the rental period for oxygen equipment from 36 months to 13 months, saving $2.4 billion over five years and $6.9 billion over ten years.

- **No Deficit Reduction**. Many of these payment reductions and cost-saving provisions are included in the bill to pay for increased spending on SCHIP and other new health programs. While some conservatives might have normally welcomed some of these provisions in an effort to slow the growth in Medicare spending and/or reduce the deficit, it is important to note that these provisions are aimed at partially offsetting *more* entitlement spending. *And*, if recent history is a guide, Congress has shown a willingness to "give back" many of those Medicare reductions later, meaning these offsets may be temporary, while the spending increases are far more permanent.

- **Marriage and Family Therapists**. H.R. 3162 deems marriage and family therapists, as well as mental health counselors, as Medicare providers and eligible for reimbursement (at the same rate as social workers). This provision costs $200 million over five years, and $600 million over ten years.

- **Rural Health Increases**. The bill provides two-year extensions (costing $1.7 billion) for certain Medicare Rural Access payments and provisions, including the following:
    - Allowing independent laboratories to bill Medicare directly for certain services;
    - Payments for certain clinical diagnostic laboratory tests;

- Payment increases for rural home health services;
- Bonus payments for certain physicians; and
- Payment increases for rural ground ambulance services.

- **New End Stage Renal Disease Program**. H.R. 3162 directs HHS to establish demonstration projects to increase public awareness about the factors that lead to chronic kidney disease, and how the disease can be prevented, diagnosed, and treated.

Medicaid:

- **Transitional Medical Assistance (TMA)**. The legislation extends Transitional Medical Assistance (TMA) through fiscal year 2009. Medicaid requires that states continue benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is known as TMA. Current law requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections or due to an increase in earned income or hours of employment.

  It is important to note that both TMA and Abstinence (Title V) have been reauthorized at the same time, since both programs used to be included in TANF (Temporary Assistance for Needy Families). On July 11th, Congress passed a temporary 3-month extension of both TMA and Title V. By extending TMA for two years in SCHIP (through FY 2009) without Title V abstinence grants, the Democrat Leadership is signaling that they have no intention of reauthorizing abstinence beyond the current September 30th expiration, thus letting the abstinence grant program expire (and leaving abstinence programs across the country with no funding for the 2007 school year and beyond). In May, Chairman Dingell confirmed that he "does not plan to extend the [Title V] grant program."

  Since both programs were included in the 3-month temporarily extension, it was assumed that the decision to extend Title V would come up again in September when TMA was reauthorized. Including TMA reauthorization (for 2 years, no less) in SCHIP, prevents that debate and limits future chances to raise awareness regarding abstinence funding.

  This bill makes a significant expansion of in-state family planning via a contraception-only Medicaid program (i.e. – intentionally excluding funds for abstinence). The bill provides women access to "family planning" (including contraceptives), while denying federal funding toward abstinence programs, thus elevating funding and programs for sexually active women over those for women who may choose to remain abstinent.

- **Family Planning**. H.R. 3162 allows states to extend family planning services and supplies to non-pregnant women up to the level of eligibility that the state has for pregnant women covered under SHCIP or Medicaid. The legislation would also provide that states no longer need a waiver to provide family planning services to a larger population of enrollees at the increased Medicaid reimbursement rate. Under current law, family planning services are reimbursed at a 90-10 matching rate in the Medicaid program. This would extend the enhanced reimbursement rate for pregnant women *to non-pregnant women* for the coverage of family planning services.

The bill would also prohibit the enrollment of these women in Medicaid unless the coverage includes medical assistance for family planning services—in effect mandating coverage of these services, even to individuals who may not actually need or want them. The bill also provides presumptive eligibility for these services. Presumptive eligibility means that family planning clinics will be permitted to enroll women in this program on a temporary basis before their actual eligibility is determined. However, such presumptive eligibility is only permitted for services provided in family planning clinics—not family planning services provided by their general health care provider.

Miscellaneous:

- **Repeals Medicare Cost Containment**. H.R. 3162 repeals a Medicare funding warning in current law know as "cost-containment," that was included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) at the behest of the RSC. This provisions requires that if the Medicare Trustees' annual report finds for two years in a row that Medicare funding from general revenues (non-payroll taxes) is projected to exceed 45 percent of Medicare spending, it would include a funding warning, which would then require the President to propose, and Congress to consider, legislation to put Medicare financing on a more sustainable path.

  Some conservatives may be concerned that the bill would repeal this provision, which is designed to monitor the growth in Medicare spending and encourage Congress to take steps to reform the program. Furthermore, the timing of this repeal is curious since the warning was just triggered in April, and thus, this Congress would likely have an opportunity to consider Medicare reform legislation next year. Instead, this legislation exacerbates Medicare's fiscal woes (see below).

- **New Mandatory Program**. H.R. 3162 creates a sizable new mandatory Comparative Effectiveness Research Program. In short, the bill creates a "Center for Comparative Effectiveness Research" within DHHS's Agency of Healthcare Research and Quality (AHRQ) to research "outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically."

  The Center would be financed through the establishment of a Health Care Comparative Effectiveness Research Trust Fund within the U.S. Treasury. The Fund would receive transfers from the Medicare Trust Funds to finance the research program for fiscal years 2008-2010. Beginning in fiscal year 2011, funding would continue to flow from the Medicare Trust Funds, but it would be supplemented by a new tax on healthcare insurance policies. The tax would be imposed on most health insurance policies at a per capita amount needed to generate $375 million annually, in conjunction with resources from the Medicare Trust Funds. The Secretary of the HHS would determine this "fair share" per capita amount. Since the bill covers all accident or health insurance policies (except for workers' compensation, tort liabilities, property, credit insurance, or Medicare supplemental

coverage), this amounts to a broad new tax on private health insurance, expected to generate at least $2 billion over ten years.

While the bill states that the issuers of these insurance policies (or the sponsors of self-insured policies) will pay this new tax, it does not (and cannot) account for the fact that this tax to the consumers will merely be passed along, raising the cost of private health insurance policies substantially. This would mean that some segment of the population could no longer afford private health care insurance and would therefore have to rely more heavily on government health care programs, many of which are expanded greatly by this legislation.

The bill would also draw down substantial funds from the Medicare Trust Funds over time, $300 million over the first three fiscal years and up to $90 million each fiscal year thereafter. Medicare Part A (hospital services) is financed by payroll taxes, and according to the nonpartisan Medicare Trustees, it is scheduled for bankruptcy in 2019—thus committing its resources for additional research will further expedite its bankruptcy. In addition, Medicare Part B (supplementary services) is financed in part from beneficiary premiums that rise as the cost of the program rises-thus tapping these funds for research amounts to a tax on every senior enrolled in Medicare Part B.

***Title X—Tax Increases*:**

- **Tobacco Tax Increase**. H.R. 3162 increases the cigarette tax by 45 cents per pack and increase the tax on large cigars from 39 to 45 cents. Some conservatives may be concerned that the bill increases taxes on low-income individuals in order to pay for the expansion of SCHIP, which is designed to assist low-income families. In addition, this revenue source is constantly declining as fewer and fewer individuals begin to smoke, since placing a tax on cigarettes will likely deter sales, leading some to question the efficacy of the offset. According a study by the Heritage Foundation, "To produce the revenues that Congress needs to fund SCHIP expansion through such a tax would require 22.4 million new smokers by 2017."

- **Fuel Excise Taxes**. H.R. 3162 exempts from fuel excise taxes "any liquid used by ambulances to provide emergency medical services."

Possible Conservative Concerns: Proponents of H.R. 3162 have encouraged the notion that this legislation is mainly an effort to reauthorize and modernize a popular low-income children's health insurance program. However, many conservatives believe that their ambitions are far greater, and that the bill represents a dramatic effort to expanding government-run healthcare at the expense of private insurance plans.

- **SCHIP Expansion**. H.R. 3162 authorizes almost $160 billion over ten years for the reauthorization and expansion of the SCHIP program. The bill transfers the program into a permanent entitlement, eliminates the income limit for eligibility, and expands the eligibility pool to include "children" up to the age of 25. SCHIP was designed to be a *limited* block grant to states, and was not created as an entitlement (such as Medicaid), which is automatically funded every year, with or without congressional approval.

- **Private Insurance Crowd-Out**. In addition, expanding SCHIP will likely cause a substantial shift away from the private health insurance market, by encouraging more and more children (and adults) to obtain health care coverage from the federal government. According to CBO, this phenomena is already occurring, "…the increase in public coverage [SCHIP] has been partially offset *by a reduction in private coverage*. …some parents *who otherwise would have enrolled their children in private coverage may prefer instead to switch their coverage to SCHIP*" (emphasis added).

- **Medicare Advantage & Tax Increases.** The bill relies on cuts to a private-sector oriented Medicare program and tax increases to pay for its SCHIP expansion. The bill reduces over $157 billion from the Medicare Advantage program and generates $53 billion in revenue from the tobacco tax increase. In addition the bill creates a new tax on most healthcare insurance policies (which still has not been fully vetted by JCT), which will likely result in rising costs in the private health insurance market.

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